BP-A0621
MAY 24

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

U.S. DEPARTMENT OF JUSTICE — **FEDERAL BUREAU OF PRISONS**

COMPLETE ALL SECTIONS, DATE, AND SIGN

I.	(PRINT) Full Legal Name *(Last, First, Middle)*: Taylor, Terrell M Other Names *(Maiden Name, Alias)*:	Register Number 47048-044	Date of Birth 02/19/1991

II. Pursuant to 5 U.S.C. Section 552a (b), I authorize the U.S. Department of Justice to:

☐ **Obtain information from** *OR* ☒ **Release information to**

Name of Person/Facility: Bhairav Radia, IFMK Law, Ltd. Phone: 847-291-0200 Fax: 708-621-5538

Address: 650 Dundee Road, Suite 475 City/State/Zip Code: Northbrook, IL 60062

III. Purpose of Disclosure: ☐ Continuing Care ☐ Disability Determination ☒ Legal ☐ Other: _____

IV. Information to be Released/Obtained: Copy of and/or information from my health record pertaining to my evaluation/treatment received from 05/12/2018 to Present.

☒ Complete Record	☒ Laboratory Reports	☒ Pathology Reports	☒ Radiology Reports
☒ Consultations	☒ Medication List	☐ Pathology Slides	☒ Radiology Film/Imaging
☒ Discharge Summary	☒ Operative/Procedure	☐ Will be returned OR	☐ Will be returned OR
☒ History & Physical	☒ Progress Notes	☐ Duplicates accepted	☐ Duplicates accepted
☒ Immunization Record	☐ Other: _____		

I authorize the release of the following sensitive information relating to:

☒ Alcohol/Drug Treatment/Referral ☒ HIV/AIDS Treatment

☒ Behavioral/Mental Health *(Other than Psychotherapy Notes)* ☒ Sexually Transmitted Diseases

V. Privacy Act Statement. In accordance with 28 CFR Section 166.41(d) personal data sufficient to identify the individuals' submitting requests by mail under the Privacy Act of 1974, 5 U.S.C. Section 552a, is required. The purpose of this solicitation is to ensure that the records of individuals who are the subject of US Department of Justice systems of records are not wrongfully disclosed by the Department. Failure to furnish this information will result in no action being taken on the request. False information on this form may subject the requester to criminal penalties under 18 U.S.C. Section 1001 and/or 5 U.S.C. Section 552a (i)(3).

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct, and that I am the person named above, and I understand that any falsification of this statement is punishable under the provisions of 18 U.S.C. Section 1001 by a fine of not more than $10,000 or by imprisonment of not more than five years or both, and that requesting or obtaining any record(s) under false pretenses is punishable under the provisions of 5 U.S.C. 552a(i)(3) by a fine of not more than $5000.

I understand that authorizing the disclosure of this health information is voluntary and not a condition of treatment. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. I understand that I may revoke this consent at any time by sending a written notice to the Supervisor of Medical Records. I understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality. This authorization will automatically **expire 90 days** from the date of the signature.

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

Signature of Patient: [signature]	**Date:** 11-7-2024
Signature of Witness/Credentials *(If required)*: [signature] RN	**Date:** 11/7/2024
(Print) Witness Name/Credentials: Sarah Ribble RN	

DEPARTMENT USE ONLY

Processed by: _____ Date: _____ Requested by: _____ ☐ No health records found

Mail or fax records to:

PDF *Prescribe by P6031*

Exhibit B